The Winding Road to EMR Adoption

A Washington physician explains why he made the transition to EMRs at the end of his career.

By David Fairbrook, M.D.

As a physician at the end of my professional career, an electronic medical record (EMR) program became a matter of responsibility rather than choice for the future. Having worked in both large and small practices, I understand that we as physicians have a responsibility to grow in our understanding of EMRs while vendors have a responsibility to provide solutions that work for small practices as well as large healthcare enterprises.

I came to Olympia, Wash. in 1976 after serving in the Navy and completing a residency at the Mayo Clinic in Rochester, Minn. I joined a large multi-specialty clinic in Washington state soon after because I wanted to focus on the practice of medicine and not be encumbered by business technicalities. The clinic, based in Olympia, had 200 physicians at its peak with 13 in the internal medicine department, making it the largest clinic in a 5-county area serving all of southwest Washington.

By 1999, the clinic had largely managed care contracts. This was a time of transition, and for a variety of reasons, the clinic did not prosper. The specialists had difficulty disbursing funds fairly to pediatricians and primary care doctors, which began to disrupt the management of the practice. Bankruptcy loomed, and the clinic was dissolved in 2001.

Prior to the closure, I had moved to a branch office with a nurse practitioner in hopes of increasing production using ancillary personnel. Upon the closure of the clinic, I assumed the lease of the branch office and started my own practice. Fortunately, I had an experienced office manager, but I knew little about billing so that was outsourced to a local billing agency. They did well for a while, but we eventually found that they were not diligent about pursuing the smaller accounts of less than $100. This ultimately cost me $36,000 in lost revenue for a year.

A change in billing agencies didn't improve matters as the new agency put us on their new computer billing system. Due to technical difficulties and lack of understanding of their system, we could not get accurate production figures. Accounts receivable information was poor and eventually the company got into financial difficulties and went bankrupt, nearly taking us with them.

EMR Education and Adoption

We had begun the practice using only paper records with a simple computer system for demographics and insurance information. In the meantime, we researched EMRs, attended symposiums and finally chose a medical records vendor for interview. Ultimately we found the nearly $80,000 cost impossible to afford. In Early 2006, our local IPA was encouraging the use of e-prescribe by their physicians, which was being offered by Purkinje CareSeries.

On further investigation of the vendor, we found that they also offered EMR and billing services. Being desperate to gain some control over our billing issues, we signed on with Purkinje to become the first beta site on the West Coast. By first entering the demographics and insurance information into the e-prescribe module, we could easily learn that portion of the system and then transfer that data over to the EMR as we transitioned into a more complete EMR/billing program.

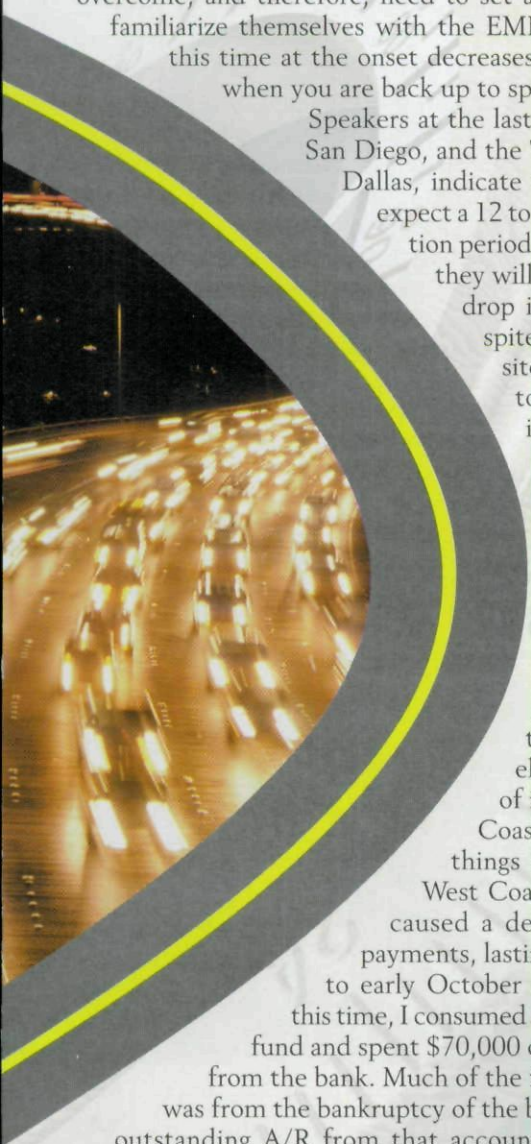
Laptop computers were purchased for the physicians and nurses, as well as some desktop computers for the front office. The Purkinje system is Web based, so I did not have the up-front purchase cost of the entire program, nor did I have the security concerns or costs for information services that might be incurred by an in-house system. A monthly fee of approximately $340 per-provider, per-month was the only outlay once the system was installed. Onsite trainers from the vendor spent two weeks at our clinic and provided the technical support. After the first few days of training, we quickly learned the basics and refined our skills during the second week.

Being a beta site, we experienced the early technical difficulties one might expect. However, the vendor support, as well as the ability to offer suggestions, discuss problems, and resolve issues in partnership with the vendor was key

to the success of the rollout. Updates and refinement of the system are continuing through clinical advisory board meetings that provide suggestions to the developers. This provides plenty of opportunity for input by all users.

Challenges of Conversion

The challenge of converting to EMR is a process that requires time. The practice needs to set aside the time it takes to standardize their office procedures so that all of the staff is doing the same process the same way. Healthcare providers need to realize that there is a learning curve to overcome, and therefore, need to set aside the time to familiarize themselves with the EMR system. Taking this time at the onset decreases frustration later when you are back up to speed.



Speakers at the last ACP meeting in San Diego, and the TEPR meeting in Dallas, indicate that a clinic can expect a 12 to 18-month transition period and that initially, they will most likely see a drop in production. In spite of being a beta site, we are on track towards completing the transition from paper record to EMR record in that time frame.

Another challenge that we experienced was difficulty getting Medicare to understand the electronic transfer of information. East Coast Medicare does things differently from West Coast. This problem caused a delay in Medicare payments, lasting from mid-July to early October of 2006. During this time, I consumed a $30,000 reserve fund and spent $70,000 on a line of credit from the bank. Much of the financial problem was from the bankruptcy of the billing agency and outstanding A/R from that account. Nonetheless, by January of 2007, I was $70,000 in debt to the bank, but by May 15, 2007, I had cleared the bank loan and today the practice has no outstanding debt.

Why Make the Switch?

There are a number of reasons for switching to EMR. Chief among them is the transfer of information between different healthcare services quickly and efficiently, in order to provide the utmost in patient care. Certainly, the ability to improve cash flow is crucial for small primary care medical practices, especially if you have Medicare patients, as most internists do.

Under our old system of outsourcing our billing, the agency would pick up claims twice a week. Dictation took as long as 48 hours in turnaround time. In this scenario, a staff member would need to collect the billing, dictation and any lab data, and have it reviewed and signed off by the provider before the claim left the clinic. Having an EMR with clinical decision support built into it, provides us the information we need for proper coding and billing. Consequently, we are able to do our own coding and select our own billing based on that clinical support system. Once we complete the visit and sign off the record, the claim is immediately sent to the scrubber and billing agencies through electronic transfer of information. Turn around time for payment averages 10 to 14 days.

During the initial rollout of the EMR, one of the front office employees quit. After reviewing the situation, the remaining staff decided that the new system would allow two employees to easily do the work of three, so that employee was not replaced. The transcription costs ran close to $4,000 per month for three providers. After the EMR was started, that cost dropped to $200 per month within a 2-month period. Recent review of clinic overhead from pre-EMR data of January 2006 to May 2006 was running at near 62 percent. After implementation of the EMR, the January 2007 to May 2007 overhead is near 52 percent, with some transition still left to complete.

Clinical Decision Support

Physicians First Watch recently quoted an article from the *Archives of Internal Medicine*, noting that EMRs alone were not associated with better ambulatory care. The article recommended that careful consideration should be given to being sure that the selected EMR includes clinical decision support. This was a key factor in our decision to move towards adopting EMR. The e-prescribe portion of the EMR lists the drugs used for any given diagnosis by priority, based on review by the pharmacy department at Washington University in St. Louis. The clinical data for that decision can be viewed by clicking on an icon that brings up the articles and supportive data.

> Healthcare providers need to realize that there is a learning curve to overcome and therefore need to set aside the time to familiarize themselves with the EMR system. Taking this time at the onset decreases frustration later when you are back up to speed.

Appropriate patient education is readily available to print for the patient to take home. Information regarding insurance company preferred drugs are available on the screen at the time of prescribing. The drugs can be dispensed from the office, by printed script given to the patient or by fax directly to the pharmacy. The e-prescribe module also monitors drug allergy and drug-drug interactions that prompt the physician to be aware of new drugs he is prescribing or interactions with old drugs the patient is already taking.

For more information on Purkinje's CareSeries suite, including EHR, PHR, e-Prescribing and enterprise PM solutions, www.rsleads.com/712ht-200.

Clinical decision support is available as clinical reminders for routine preventive care recommendations. Prompts are available to remind the physician when labs are due as a part of monitoring drug side effects. Coding support is present to help the physician code the most accurate and complete ICD-9 code, which has the greatest likelihood for being paid. Required associative diagnoses for diabetic, cardiac and other complex patients are listed so that the physician gets full credit for treating complicated patients.

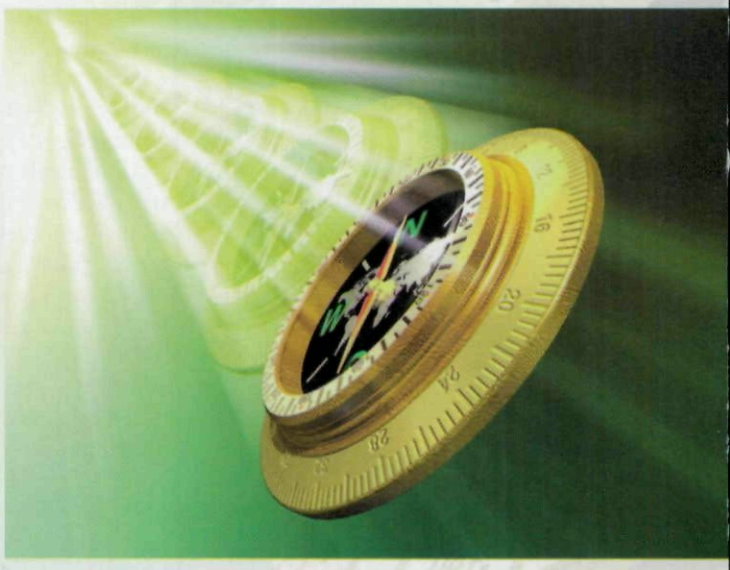
The clinical decision support feature of the EMR is a key item for future documentation that will be required by Medicare and insurance companies. It is apparent that they will be asking the physicians for documentation or proof of the quality of care that they provide their ambulatory patients.

Back to the Future

On a personal level, I believe that it is the responsibility of the retiring physician to pass the baton of medical care to the next generation in the most up-to-date, sophisticated manner possible. Five years have been spent in an attempt to find a physician to take over this practice. I realized that the new generation, with their computers, cell phones, portable media players and Bluetooth technology weren't going to appreciate my 30-year-old paper charts.

In 2004, the President declared that electronic health records were the future of healthcare, ushering in the permanent age of health IT. The July 2007 onset of Medicare asking physicians to voluntarily provide G-codes for 75 different diseases will lead to some kind of performance indicators for physicians. The future calls for the transfer of healthcare information in a manner that improves healthcare delivery for our entire population.

Physicians, by nature, tend to be hesitant and slow to adapt. Certainly, some physicians of my generation are simply playing out their time with their paper charts and sticky notes, and letting the next generation deal with computers. I believe we can do better. I believe that if the primary care physician is to survive in this specialty-based healthcare system, they must do all they can to decrease their overhead cost, increase their cash flow, and improve their efficiency and quality of care provided to their patients.



David Fairbrook, M.D., can be reached at dfairbrook@qwest.net.

HMT